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Family's Many Faces – La famille au pluriel

Contemporary Family Patterns, Challenges for Christians – Les modèles familiaux contemporains, défis pour les Chrétiens

PEETERS
LEUVEN – PARIS – WALPOLE, MA
2014

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A Sexual Life for Persons with a Psychiatric Problem? The Parallel Discourses of Ethics and Psychiatry on Sexuality

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For many years the sexual lives of people with psychiatric problems were not discussed. Instead, they were ignored and forgotten. Those people were given little chance to express their sexuality and almost no chance to start a family. In recent decades, there has been increasing openness on this subject. This is the result of a positive evolution in both the ethical discourse and the psychiatric discourse. In this article we will be examining the developments in these discourses, as a result of which ethics and psychiatry are now able to articulate a response to the issues relating to the sexuality of people with psychiatric problems. In so doing, we will look at the ways in which both discourses have followed a parallel path through a number of different paradigms.

Parallel discourses

Ethics and psychiatry

Ethicists have spoken since time immemorial about the 'good life' and there is no doubt that sexuality forms an important part of this good life. The ethicists seek to guide people in their search for the good life by clarifying and making explicit the implicit choices relating to particular values and responsibilities. Psychiatrists are more concerned with human desires. This obviously includes sexual desire. On the basis of a bio-psycho-social approach, they guide people in their efforts to achieve harmonious personal development by offering them insights into their desires and personalities, their possibilities and limitations. Does this mean that the ethicists and the psychiatrists are essentially dealing with the same thing?

Of course, it is easy to make a case that the ethicists and the psychiatrists are dealing with very different things. They each have their own field of research, which gives their respective sciences and practices their

distinctive nature. They both have their own well defined territory of human reality within which they operate and to which they attempt to bring a specific method of understanding and organization. To achieve this, they both use their own scientific language, their own technical and academic concepts and their own logic. They both work within their own institutional framework, which gives them a specific identity. These institutions also have their own training, hierarchy, channels of communication, infrastructure and financial resources. But is the difference between ethics and psychiatry really to be found in these matters?

Discourses

It is our opinion that the respective discourses of ethics and psychiatry seem to follow a parallel path. In this context, we take the term 'discourse' to mean anything and everything that is thought, written or said about the theory and practice of ethics or psychiatry. When we speak of 'parallel discourses', we mean that the individual discourses of the two disciplines seem to operate side by side.[1] They are like the two lengths of a ladder that run parallel. Actually, the discourses display many similarities by virtue of the fact that in part they are both attempting to interpret the same reality. They are linked with one another, like the rungs of the ladder connect the two lengths.

The boundaries between the different discourses are not always clear: no human science has a monopoly over its own specific part of the human condition. In this sense, there is always a grey area of discontinuity between the different human sciences. If we bring them together, they do not necessarily give us a total picture of mankind. They are not like pieces of a puzzle, which only need to be fitted together in the right order to reveal the overall pattern. On the contrary, the same part of reality is frequently a subject for investigation in several different human sciences. Consequently, the fields of investigation of the human

[1] The concept of 'parallel discourses' has been introduced by P. VANDERMEERSCH, *Ethiek tussen wetenschap en ideologie* [Ethics between Science and Ideology], Leuven, 1987, pp. 24-27. The concept is inspired by the work of Michel Foucault, cf. M. FOUCAULT, *Les mots et les choses. Une archéologie des sciences humaines* (Bibliothèque des sciences humaines), Paris, 1966; Id., *L'archéologie du savoir* (Biliothèque des sciences humaines), Paris, 1969; Id., *L'ordre du discours. Leçon inaugurale au Collège de France prononcée le 2 décembre 1970*, Paris, 1971. The concept has been the theoretical and methodological foundation of a study on the relation between ethics and psychiatry, cf. A. LIÉGEOIS, Hidden Philosophy and Theology in Morel's Theory of Degeneration and Nosology, in *History of Psychiatry* 2, 1991, pp. 419-427.

sciences are better compared with a cubist painting, where the patterns overlap.

This concept of parallel discourses is useful for explaining the relationship between ethics and psychiatry.[2] They are different scientific disciplines, but they function alongside each other in parallel. We are pleading for greater recognition and awareness of the parallel nature of and the connections between these discourses. This implies that both ethicists and psychiatrists must learn to understand that the realities which they study are not necessarily confined to their own discipline. This in turn means that the choices they make in their own discourse are also related to choices made in the other discourse. For this reason, it is important that ethicists and psychiatrists should become more familiar with each other's disciplines. If ethicists seek to help people by clarifying the implicit values and responsibilities inherent in their desire for the good life, they must nevertheless concede that this desire is shaped by the psyche of people, with all their many possibilities and limitations. Likewise, if psychiatrists seek to help people to achieve harmonious development by giving them insights into their psychological functioning, they cannot escape the conclusion that this guidance involves choices relating to values and responsibilities.

Paradigms

The parallel nature of the discourses is particularly clear if we view matters from a historical perspective and focus in particular on sexuality.[3] It is possible to distinguish between a number of different paradigms in the historical development of the ethical and psychiatric discourses. The term 'paradigm' is taken to mean the general theoretical framework within which the reality of a particular discourse is interpreted in a particular period and culture. In this context, it is possible to distinguish

[2] For the differentiation between psychiatry and ethics, See B. KIELY, *Psychology and Moral Theology. Lines of Convergence*, Rome, 1980, pp. 1-11; 249-272; Don. S. BROWNING, *Christian Ethics and the Moral Psychologies*, Grand Rapids, 2005, pp. 1-16.

[3] We have elaborated the historical development of the psychiatric discourses in chapter 1 on the 'care relationship' in A. LIÉGEOIS, *Waarden in dialoog. Ethiek in de zorg* [Values in Dialogue. Ethics in Care], Leuven, 2011, 2nd edition, pp. 27-42; See. A. LIÉGEOIS & M. ENEMAN, An Ethics of Deliberation, Consent and Coercion in Psychiatry, in *Journal of Medical Ethics* 34, 2008, pp. 73-76. We also elaborated the historical development of the sexual discourses in chapter 9 on 'sexuality' in A. LIÉGEOIS, *Begrensde vrijheid. Ethiek in de geestelijke gezondheidszorg* [Limited Freedom. Ethics in Mental Health Care], Kapellen, 1997, pp. 147-162.

three district paradigms, namely a traditional, an emancipatory and a relational paradigm. All three paradigms are evident in the development of both the ethical discourse and the psychiatric discourse. And the comparable development of these paradigms is clear evidence of the parallel nature of those discourses.

A case study

To ensure that our own discourse is grounded in practice, throughout this article we will discuss the issues raised with reference to a case study.

Helen is 32 years old and suffers from schizophrenia. About five years ago, she was admitted to a psychiatric clinic. Her condition is now stable, providing she takes her medication. For the last two years she has been living in sheltered accommodation. During the day, she attends a centre for work rehabilitation. It was there that she got to know Peter. He is a little older than Helen and also suffers from schizophrenia. He lives at home with his parents. Helen has a very strong desire to have children. Sometimes she realizes that she will not be able to raise a child by herself. To solve this problem, she thinks that the child can be cared for by her parents or in a home. The parents are not happy with this idea and are convinced that it would be better if she did not become pregnant. They approach the caregivers and ask them to ensure that this does not happen. How should the caregivers react in this situation?

The traditional paradigm

The professional caregiver

The traditional paradigm in the psychiatric discourse emphasizes the professionalism of the caregivers.[4] One of the caregiver's most important therapeutic tools in psychiatric treatment is the relationship with the patient. This relationship is asymmetrical: the patient and the caregiver are not equal partners and there is a structural imbalance of power in favour of the caregiver.[5] The patient has a psychiatric problem that he

[4] See A. LIÉGEOIS, *Waarden in dialoog* [Values in Dialogue], pp. 28-30.

[5] See K. LEBACQZ, *Professional Ethics. Power and Paradox*, Nashville, 1985, pp. 109-151; R. GULA, *Just Ministry. Professional Ethics for Pastoral Ministers,* Mahwah NJ, 2010, pp. 117-155.

or she is no longer able to solve, not even with the assistance of his or her concerned others. For this reason, the patient needs to turn to the professional caregivers for help. With their specialized knowledge, skills and attitude, they can do what the patient is unable to do for him- or herself. In this view, it is not surprising that the traditional paradigm in psychiatry places such a heavy emphasis on the professionalism of the caregivers. It is their professional expertise, in combination with their human commitment, which forms the basis for good psychiatric treatment. Consequently, it is the caregivers who decide what is good for the patient, basing their decisions on their knowledge and experience. The professional responsibility of the caregivers is therefore central.

The basis for this paradigm is to be found in the Hippocratic traditions of medicine. In the Hippocratic Oath emphasis is placed on two core elements of care: doing the best possible for the patient and not harming the patient. In other words, the doctor must do everything possible to heal or cure the patient and must do nothing to damage the patient or endanger his or her life. These two duties have been construed as the principles of 'beneficence' and 'non-maleficence'.[6] This paradigm is also grounded in the Christian tradition. In Christian morality, the virtue of 'caritas' is fundamental: people can only love God by also loving their neighbours. Caritas therefore encourages doing good for the people around you, in a manner which requires you to minimize self-interest and concentrate on the 'poor' and 'needy'. Christian charity therefore goes hand in hand with good medical care. Moreover, the basic Christian respect for the 'sanctity of life' as created by God in his image, is wholly compatible with the medical obligation not to harm patients. In other words, there is a parallelism between the charitable 'doing good' of Christians and the professional 'doing good' of doctors. This parallelism has been evident throughout much of history. For many centuries religious people, inspired by their sense of charity, took care of psychiatric patients.[7] In so doing, they worked in close collaboration with the doctors, who treated these patients in accordance with the duty imposed on them by their Hippocratic Oath.

[6] For a discussion of the principles of non-maleficence and beneficence, see. T. BEAUCHAMP & J. CHILDRESS, *Principles of Biomedical Ethics*, New York/Oxford, 2009, 6th ed., pp. 149-239.

[7] For an example of this collaboration, see C. FINO, *L'hospitalité, figure sociale de la charité. Deux fondations hospitalières à Québec,* Paris, 2010.

We can apply this traditional paradigm in the psychiatric discourse to matters of sexuality, and in particular to the case of Helen and Peter. In this paradigm the caretakers use their professional expertise to decide what is good for the patient. And indeed, the caregivers do have valid and valuable insights into the way in which schizophrenia can influence sexuality. Because schizophrenic patients can sometimes have problems to make effective contact with other people, there is often a reduced motivation for sexual activity and a lower level of commitment towards the partner. This reduced interest in sexuality is frequently a result of the medication that the schizophrenic is required to take. Moreover, this medication can also have harmful effects on the foetus during pregnancy. Based on these psychiatric considerations, the caregivers will probably seek to limit the possibilities for sexual contact between Helen and Peter, and they will certainly seek to prevent her from becoming pregnant, as long as she is receiving medication. In the past, the application of this paradigm would have been accompanied by stringent measures. In order to achieve their objectives, the caregivers would make physical contact between Peter and Helen impossible and would ensure that Helen was 'protected' against pregnancy by the obligatory use of contraception, including sterilization, if this was deemed to be necessary.

The married family

These considerations of sexuality within the context of the psychiatric discourse lead us automatically to the approach adopted towards sexual matters in the ethical discourse. The ethical discourse also has a traditional paradigm.[8] Sexuality is placed within the framework of marriage and marriage is seen as the lifelong relationship of love between a man and a woman, for the specific purpose of procreation. The civil and religious marriage therefore imply acceptance of a number of values and norms that regulate the internal relationship between the man and the woman, and their joint external relationship with society at large. In this sense, marriage offers a protective structure for the sexual expression of the partners, procreation and the raising of children.

The classic married family with parents and children occupies a central position in this traditional paradigm. This implies a strong ethic with strict norms, which is expressed in its most explicit form in the

[8] See A. LIÉGEOIS, *Begrensde vrijheid* [Limited Freedom], pp. 154-156.

moral teaching of the Roman Catholic Church.[9] The church believes that sexual intercourse is only appropriate within the context of a married relationship between a man and a woman. Moreover, sexual intercourse must have as its purpose the procreation of children, so that the artificial prevention of procreation through the use of contraceptive techniques or assistance to procreation by means of a medical intervention is forbidden. Other forms of sexual expression are not permitted. This ethic sets a very high standard of moral behaviour, which people are not always able or willing to meet. However, the church shows pastoral understanding and forgiveness when people fail to live up to its high expectations. Nonetheless, many people regard this attitude as condescending and paternalistic. They have difficulty with the fact that the church says to respect the person, but disapproves the behaviour as sinful.

If we apply this paradigm to the case of Helen and Peter, the matter is simple. Helen and Peter are not married and therefore sexuality is not appropriate in their relationship. With regard to a possible marriage between Helen and Peter, the traditional paradigm would also view this possibility unfavourably. Even though their schizophrenia is stabilized, their condition imposes a number of serious limitations which makes them unfit for marriage and the raising of children.

Heteronomous setting of norms

If we seek the ethical foundations of the traditional paradigm in both the psychiatric and the ethical discourses, the parallel nature of their development becomes apparent. In both cases, the patient does not make decisions for him- or herself and is not even consulted about these decisions. Instead, the decisions are imposed by external factors or external parties. In the psychiatric discourse, the decisions are taken by the caregivers. In the ethical discourse, the decisions are imposed by the model of the idealized married family. In both cases, the setting of norms is therefore heteronomous: the applicable standards of behaviour are set and enforced by someone else. This parallelism should not surprise us. The traditional paradigm follows a similar path in the history of both discourses and was prominent in their thinking from the beginning of the 19th century until the 1960s. Moreover, the traditional paradigm in both discourses was strongly influenced by Christianity; in other words, Christian norms had a powerful impact on both the ethical and psychiatric approach to matters of sexuality.

[9] See *Catechism of the Catholic Church*, London, 1999, rev. ed., nrs. 2331-2400.

The emancipatory paradigm

Informed consent

The emancipatory paradigm developed as a response to the traditional paradigm, which eventually came to be seen as too paternalistic.[10] By paternalism, we mean that the caregivers act on the basis of what they believe to be good psychiatric treatment, but without giving the patient sufficient chance to participate in the decision-making process, even if the patient is capable of making a valid contribution to this process. For this reason, the emancipatory paradigm places the emphasis on the personal responsibility of the patient. This paradigm contends that it is no longer acceptable that the caregivers alone should decide what is good for the patient. Instead, the patient must now be offered choices about the care he or she receives. This idea is expressed in the principle of respect for the patient's autonomy.[11]

The origins of this paradigm are to be found in the Enlightenment. During this period, philosophers began to argue that people should dare to think for themselves and should free themselves from the custodial stranglehold of the church and other institutions of authority. This emancipatory thinking only made its breakthrough in the field of health care in the 1960s, as part of the wider emancipatory movement associated with that decade. Since then, it has remained the dominant factor in the legislation and organization of health care.

Even so, the exercising of patient autonomy in the field of psychiatry is not easy. We have already mentioned how the patient and the caregiver share an asymmetrical relationship: the 'needy' patient asks psychiatric help and the 'expert' caregiver can offer that help. In this situation, how can the patient possibly decide about the treatment to be given? To correct this imbalance in the patient and caregiver relationship, it was necessary to develop a new concept both in ethics and in law: the concept of informed consent. This means that the caregivers can only perform a medical intervention if they have first informed the patient about the different possible treatments and have received his or her free and prior consent for the use of one of those treatments.[12] The

[10] See A. LIÉGEOIS, *Waarden in dialoog* [Values in Dialogue], pp. 30-33.

[11] For a discussion of the principle of respect for autonomy, see T. BEAUCHAMP & J. CHILDRESS, *Principles of Biomedical Ethics*, pp. 99-148.

[12] For a discussion of the concept of informed consent, see. T. BEAUCHAMP & J. CHILDRESS, *Principles of Biomedical Ethics*, pp. 117-140; R. FADEN, T. BEAUCHAMP & N. KING, *A History and Theory of Informed Consent,* New York, 1986, pp. 114-150.

patient also has the right to refuse all the proposed treatments. This is a relatively straightforward process if the patient is deemed to be mentally capable. But the matter immediately becomes more complex if the mental capacity of the patient is open to question, as is often the case in psychiatry. The ability to give informed consent implies that the patient is mentally competent to understand the proposals put forward by the caregivers and is able to assess these proposals responsibly, in the light of their own self-interest. It is for this reason that both law and ethics make provision for the appointment of a representative, who can make decisions that the patient is unable to make for him- or herself. This representative is usually someone from the immediate family circle.

This emancipatory paradigm in the psychiatric discourse can also be applied to matters of sexuality, and in particular to the case of Helen and Peter. The choice to engage in a sexual relationship and to become pregnant is now a matter for the personal autonomy of the patients. It is part of their private lives and consequently the caregivers have no right to interfere. Nevertheless, it should be noted that even outside the domain of psychiatric care caregivers often have serious doubts about the wisdom of sexual relations between certain patients, because of their social or psychological limitations. Are Helen and Peter perhaps the victims of a form of psychiatric care where the caregivers are over-diligent? The caregivers can only seek to guide the relationship and prevent a pregnancy if they have first informed Helen and Peter about the various possibilities for the future, have explained the advantages and disadvantages of these possibilities, and have received their prior consent for any intervention that may be agreed.

Individual desire

It was not only in the psychiatric discourse that there was eventually a reaction to the restrictiveness of the traditional paradigm. There was a similar reaction in the ethical discourse. The development of an emancipatory paradigm with regard to sexuality can be dated to the 1960s, a decade that saw a social movement in favour of the emancipation of women and heralded in the so-called 'sexual revolution'.[13] The central element in this paradigm is the individual gratification of desire. Desire in this context means both sexual longing and the sexual pleasure that

[13] See A. LIÉGEOIS, *Begrensde vrijheid* [Limited Freedom], pp. 151-153.

results from the satisfaction of that longing. On the basis of their freedom of choice, individuals decide whether or not to enter into a sexual relationship. This sexual relationship is intended first and foremost to satisfy personal longings; the longings of others are a secondary consideration. By focusing on the needs of the individual in this manner, this paradigm has an emancipatory effect in relation to the traditional paradigm, in which people were not able or were too intimidated to stand up for their own 'right' to sexual gratification. Moreover, by concentrating on the satisfaction of personal desires as the mainspring of human actions, this paradigm corresponds closely to the biological and psychological aspects of sexual development, in which sexual passion is the main driving force. In this sense, the emancipatory paradigm is very realistic. Many people do indeed behave in accordance with this vision.

The emancipatory paradigm has its own ethic. The concept of individualism implies more than mere self-centredness, but also relates to values such as autonomy, independence and freedom. The individual seeks to satisfy his or her individual needs. But these needs are nonetheless subject to the limitations of certain norms. Within the emancipatory paradigm, there are two generally accepted norms: the norms of non-compulsion and non-harm. The individual may act to achieve his or her own personal autonomy, but must also have respect for the personal autonomy of others. In other words, the partners may not force each other to engage in sexual activity. Likewise, they may not cause harm to each other's physical and psychological integrity. On the contrary, they must respect and protect each other's integrity.

If we look at the case of Helen and Peter from the perspective of the emancipatory paradigm, they are immediately given more possibilities to seek the satisfaction of their sexual desires. The case implies that they both wish to opt for a sexual relationship. But if this relationship should lead to pregnancy, this automatically brings the future child as a third person into the equation. This means that non-harm of the physical and psychological integrity of the child must also be guaranteed. To what extent will Helen and Peter be able to raise the child in a safe and proper manner, even with the necessary assistance? This is something that is very difficult to assess. However, there is much more certainty that the physical and psychological integrity of the child will be damaged if Helen continues to take her medication during any pregnancy. This biological fact will impose its own limitations on the development of their sexual relationship.

Autonomous setting of norms

If we seek the ethical foundations of the emancipatory paradigm in both the psychiatric and the ethical discourses, the parallel nature of their development once again becomes apparent. In both cases, people are now free to make their own choices. In the psychiatric discourse, patients have the right to give their informed consent before any medical intervention can take place. In the ethical discourse, people now have the possibility to stand up for their own 'right' to sexual gratification. In both cases, the setting of norms is therefore autonomous: the applicable standards of behaviour are determined by the individual. And once again, this parallelism should not surprise us. The emancipatory paradigm made its breakthrough in both discourses at the same moment in history in the 1960s, since when it has continued to be the dominant factor. Moreover, both paradigms have been strongly affected by the reaction against the traditional influence of Christianity; in other words, Christian norms are losing ground in the face of norms set by individuals.

The relational paradigm

Consultation between caregivers and patient

The aim of the relational paradigm is to provide an alternative to the traditional and emancipatory paradigms in the psychiatric discourse.[14] Both these paradigms have positive and negative elements. The traditional paradigm strongly values the professional responsibility of the caregivers, but runs the risk that this emphasis may lead to paternalism. The strength of the emancipatory paradigm is its focus on respect for the personal responsibility of the patient through the concept of informed consent. But in the event that the patient is mentally incapable of giving proper informed consent, the only alternative is to ask for this consent from the legal representative. Another weak point of the emancipatory paradigm is that it runs the risk of reducing the caregivers to little more

[14] See A. LIÉGEOIS, *Waarden in dialoog* [Values in Dialogue], pp. 33-42. This relational approach can be situated in the lager context and movement of care ethics, see J. TRONTO, *Moral Boundaries. Political Argument for an Ethic of Care,* New York/London, 1993; A. VAN HEIJST, *Professional Loving Care. An Ethical View of the Health Care Sector,* Leuven, 2011.

than the implementers of the patient's wishes. If the concept of informed consent is formulated too rigidly, the caregivers will be forced to comply with the patient's wishes, even in cases where their professional expertise convinces them that this is not in the best interests of the patient's welfare or health.

This is the fundamental criticism of the existing paradigms. They both take as their starting point the individual or a group of individuals, i.e. the patient or the caregivers, whom they then view separately. It is either the caregivers who decide on the basis of their professionalism or it is the patient who decides on the basis of his or her informed consent. However, it is possible to construct a third paradigm, which approaches the problem from a relational perspective. This approach is founded on three key elements: the caregivers, the patient and the relationship between them. People are no longer just individuals, but are persons in relation to others. The relational paradigm therefore proposes a radical focus on the relationship in all aspects of the care process, including the making of decisions.

This has important consequences for psychiatric treatment.[15] In the relational paradigm, the individual ceases to be central. Instead, it is the relationship between all the individuals involved in the situation that now counts: this means the caregivers and the patient and the concerned others. As a result, decisions about treatment are not taken by any one individual, but following a process of consultation between all the interested parties. If the caregivers, the patient and the concerned others can all agree to a specific line of treatment, this implies that the legal requirements for prior informed consent have automatically been met. It also implies that caregivers regard the proposed treatment as professionally responsible.

This relational paradigm in the psychiatric discourse can also be applied to matters of sexuality, and in particular to the case of Helen and Peter. The innovative aspect of this paradigm is that the caregivers now enter into a dialogue with Helen and Peter. If the couple agree, the caregivers can also involve the concerned others in this process. It is already known, for example, that Helen's parents are concerned about

[15] See A. LIÉGEOIS, *Waarden in dialoog* [Values in Dialogue], pp. 109-123; A. LIÉGEOIS & M. ENEMAN, An Ethics of Deliberation, Consent and Coercion in Psychiatry, pp. 73-75. For further literature on the relational approach, cf. R. FRANKEL, T. QUILL & S. MCDANIEL, *The Biopsychosocial Approach. Past, Present and Future,* Rochester NY, 2003; M. KOLOROUTIS (ed.), *Relationship-Based Care. A Model for Transforming Practice,* Minneapolis, 2004.

the prospect of a pregnancy. The caregivers can act as advocates for the relationship between Helen and Peter, and can argue in favour of their right of autonomy. At the same time, the caregivers can also use their professional expertise to look critically at the possible influence of schizophrenia on the relationship and any resulting pregnancy. For this reason, the caregivers will inform Helen, Peter and their concerned others about what a sexual relationship and an eventual pregnancy might mean. They will formulate a proposal to guide the relationship, whilst keeping an open mind towards the future possibility of children. In this way, they motivate Helen, Peter and the concerned others to accept the proposal, but are also prepared to modify their views in response to valid arguments that these other parties may put forward. The precise position adopted by the caregivers will, however, depend on the paradigm they favour with regard to the ethical discourse on sexuality.

The relationship between both partners

A relational paradigm is also possible in the ethical discourse on sexuality.[16] This paradigm does not take the individual gratification of desire as its starting point, but focuses instead on the relationship between the two partners. This relationship also consists of three key elements: the first partner, the second partner and the relationship between them. In other words, the relational aspect includes the individual gratification of each partner's desire, which is their 'right' in terms of the emancipatory paradigm. But the relational paradigm places the relationship in the central position and approaches the individual gratification of desire through the partners' experience of their relationship. The relationship can only develop if it includes the gratification of the desire of both partners, but the experience of gratification only acquires its value by virtue of the focus on the other and the recognition of the other. In this paradigm, sexuality and relatedness are inextricably interlinked.

The relational paradigm also has its own ethic.[17] It is a relational ethic in which the relationship is central. The paradigm expounds an ideal

[16] See A. LIÉGEOIS, *Begrensde vrijheid* [Limited Freedom], pp. 153-154; 157-162.

[17] For a theoretical foundation of this relational vision of sexuality, see R. BURGGRAEVE, *Zinvolle seksualiteit. Een integraal-relationele achtergrondvisie in christelijk perspectief* [Meaningful Sexuality. An Integral-Relational Vision in Christian Perspective], Leuven, 3rd rev. ed.; R. BURGGRAEVE, Historical Building Blocks for a Consistent Relational and Sexual Ethics, in J. KEENAN (ed.), *Catholic Theological Ethics. Past, Present, and Future. The Trento Conference*, Maryknoll NY, 2011, pp. 86-95.

situation in which sexuality is experienced through a relationship. This is by no means evident, since sexuality by its very nature is not focused on the relationship with the other, but on the gratification of personal sexual desire. However, sexuality is not simply a biological and psychological phenomenon, but is also a human phenomenon, which therefore allows it to be experienced in a relationship. Moreover, this relationship can be qualified with values such as equality and reciprocity, freedom and responsibility, love and solidarity, loyalty and durability.

Unfortunately, this ideal is not always attainable or, in the eyes of some, desirable. Nevertheless, in reality there are boundaries which it is important not to cross. In this respect, the relational paradigm embraces the generally accepted norms of the emancipatory paradigm, namely that the partners must not force each other to do something, nor should they damage each other's personal integrity.

This brings us to the question of guidance and counselling based on the relational paradigm. The caregivers take as their starting point the life situation, possibilities and limitations of the patients. The caregivers help and guide them through a process of dialogue, bearing in mind their values and norms. But the guidance itself is not neutral, not without values and norms. The caregivers must ensure the protection of the minimum boundaries and seek to achieve the relational ideal.

If we apply counselling on the basis of the relational paradigm to the case of Helen and Peter, the relationship now stands central. The paradigm encourages the couple to make something positive of their relationship. It also encourages the caregivers to enter into dialogue with Helen and Peter. The caregivers can explain possibilities that might allow them to further develop their relationship and experience more intimacy than was hitherto possible. They can advise them about their approach to each other and possibly prepare them for living together. If the relationship nevertheless fails, Helen's desire to become pregnant will probably diminish.

If the partner relationship continues to grow, a sufficiently strong foundation for a parenthood relationship may result. The caregivers can advise Helen and Peter in their approach toward their future child and prepare them for eventual parenthood. If the responsibility of parenthood is too heavy for them to bear, the caregivers will guide them through the acceptance process and help them to live a life without children of their own.

No matter how far Helen and Peter are able to develop their relationship, they will continue to be confronted by the minimum boundaries.

An eventual pregnancy must not be allowed to damage the integrity of the unborn child, and this will certainly be the case if Helen continues to take her medication. Precisely because Helen and Peter must live with a number of limitations as a result of their psychiatric problems and treatment, it is important that they should enter into dialogue with the caregivers. On the basis of the relational paradigm, the caregivers can help Helen, Peter and their concerned others to search for what is feasible and can show them where the boundaries lie.

Inter-subjective setting of norms

If we seek the ethical foundations of the relational paradigm in both the psychiatric and the ethical discourses on sexuality, the parallel nature of their development yet again becomes apparent. In both cases, relatedness is now central. In the psychiatric discourse, choices are made following a process of consultation between the caregivers, the patients and their concerned others. In the ethical discourse, the relationship between both partners is taken as the fundamental starting point. In both cases, the setting of norms is therefore inter-subjective: the applicable standards of behaviour are determined by all those involved, following a process of dialogue. This allows a middle course to be steered between autonomy and heteronomy, between subjectivity and objectivity. For this reason, the relational paradigm is now winning important ground in both the psychiatric and ethical discourses, and is also compatible with the care-ethic approach towards health care in general. Although the relational paradigm is therefore a viable alternative to the other paradigms, for the time being the precepts of the emancipatory paradigm continue to be the dominant factor in the regulation of the health care system. It is likely that the relational paradigm will remain in a subordinate role, because it expounds an ideal situation that is not always achievable and appeals to the freedom and responsibility of those involved. In contrast, the emancipatory paradigm has a stronger legal anchoring and is more in keeping with the individualistic focus of most people.

Conclusions

The concept of parallel discourses is a useful one for comparing the relationships between the different human sciences. The discourses run alongside each other. Without the scientists and academics always being

aware of the fact, they refer to the same reality and develop similar paradigms. It is this last point in particular that we wish to illustrate in this present article. The historical evolution of the psychiatric and ethical discourses both display a parallel development of paradigms; namely, from a traditional paradigm to an emancipatory paradigm, with a relational paradigm as a third alternative. The foundations of the paradigms are the same in both discourses.

This gives us a strong argument in favour of interdisciplinary cooperation. Such arguments are usually practical or utilitarian in nature. However, the concept of parallel discourses allows us to see that there are also more fundamental arguments, since both discourses clearly show parallelism in the development of their paradigms. This insight offers a powerful motive for further interdisciplinary research and interdisciplinary collaboration in the care sector.

It also gives us an equally strong argument to take our changing attitudes towards the question of sexuality in psychiatric patients a step further. The development of the discourse from a traditional to an emancipatory vision has been a very positive one. To this, we would wish to add the alternative of a relational vision, since this vision takes full account of the involvement of all concerned and of sexuality as a relational given.